

**[IN ACCORDANCE WITH CALIFORNIA INSURANCE CODE (CIC) SECTION 12938,
THIS REPORT WILL BE MADE PUBLIC AND PUBLISHED ON THE
CALIFORNIA DEPARTMENT OF INSURANCE (CDI) WEBSITE]**

**WEBSITE PUBLISHED REPORT OF THE MARKET CONDUCT
EXAMINATION OF THE CLAIMS PRACTICES OF**

**NATIONAL TEACHERS ASSOCIATES LIFE
INSURANCE COMPANY
NAIC # 87963 CDI # 4418-0**

AS OF SEPTEMBER 30, 2008

ADOPTED MARCH 14, 2012

STATE OF CALIFORNIA



**CALIFORNIA DEPARTMENT OF INSURANCE
MARKET CONDUCT DIVISION
FIELD CLAIMS BUREAU**

NOTICE

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code (CIC) describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. The following examination report is a report that is made public pursuant to California Insurance Code Section 12938(b)(1) which requires the publication of every adopted report on an examination of unfair or deceptive practices in the business of insurance as defined in Section 790.03 that is adopted as filed, or as modified or corrected, by the Commissioner pursuant to Section 734.1.

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DEPARTMENT OF INSURANCE

Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013



March 14, 2012

The Honorable Dave Jones
Insurance Commissioner
State of California
300 Capitol Mall
Sacramento, California 95814

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims handling practices and procedures in California of:

**National Teachers Associates Life Insurance Company
NAIC # 87963**

Group NAIC # 0000

Hereinafter, the Company listed above also will be referred to as NTAL or the Company.

This report is made available for public inspection and is published on the California Department of Insurance website (www.insurance.ca.gov) pursuant to California Insurance Code section 12938(b)(1).

FOREWORD

The examination covered the accident and disability claims handling practices of the aforementioned Company on claims closed during the period from October 1, 2007 through September 30, 2008. The examination was made to discover, in general, if these and other operating procedures of the Company conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains all alleged violations of laws that were identified during the course of the examination.

The report is written in a “report by exception” format. The report does not present a comprehensive overview of the subject insurer’s practices. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer’s proposals for correcting the deficiencies. When a violation that reflects an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Company’s responses, if any, have not undergone a formal administrative or judicial process.

SCOPE OF THE EXAMINATION

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of the California Insurance Code, Fair Claims Settlement Practices Regulations, and other related statutes, regulations and case law used by the Company to ensure fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claims files and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results; a review of consumer complaints and inquiries about the Company closed by the CDI during the period October 1, 2007 through September 30, 2008; a review of previous CDI market conduct claims examination reports on the Company; and a review of prior CDI enforcement actions.

The review of the sample of individual claims files was conducted at the offices of the California Department of Insurance in Sacramento, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The accident and disability claims and policy rescissions reviewed were closed from October 1, 2007 through September 30, 2008, referred to as the “review period”. The examiners randomly selected 63 specified disease claims files, four disability income claims files, and two accident only claims files for examination. All of the Company’s eight policy rescissions involving claims were reviewed. The examiners cited 29 alleged claims handling violations of the California Insurance Code and other specified codes from this sample file review.

Findings of this examination included failure to reference the California Department of Insurance in claim denials and failure to send written claim denials.

RESULTS OF REVIEWS OF MARKET ANALYSIS, CONSUMER COMPLAINTS AND INQUIRIES, PREVIOUS EXAMINATIONS, AND PRIOR ENFORCEMENT ACTIONS

Market analysis did not identify any specific issues of concern.

The Company was the subject of no California consumer complaints and inquiries closed from October 1, 2007 through September 30, 2008, in regard to the lines of business reviewed in this examination.

There have been no prior claims examinations conducted upon this Company.

The Company was the subject of no enforcement actions taken by the Department.

DETAILS OF THE CURRENT EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

NTAL SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED CITATIONS
Accident and Disability / Specified Disease	3,386	63	9
Accident and Disability / Short Term Disability Income	342	4	10
Accident and Disability / Accident Only	59	2	2
TOTALS	3,787	69	21

NTAL SAMPLE POLICIES REVIEW			
LINE OF BUSINESS / CATEGORY	POLICIES IN REVIEW PERIOD	SAMPLE POLICIES REVIEWED	NUMBER OF ALLEGED CITATIONS
Accident and Disability / Policy Rescissions with Claims	8	8	8
TOTALS	8	8	8

TABLE OF TOTAL CITATIONS

Citation	Description of Allegation	NTAL Number of Alleged Citations
CCR §2695.7(b)(3) *[CIC §790.03(h)(3)]	The Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.	10
CCR §2695.7(b)(1) *[CIC §790.03(h)(13)]	The Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given. or The Company failed to provide in its written denial a reference to and explanation of the applications of specific statutes, applicable laws, and policy provisions, conditions or exclusions.	9
CCR §2695.4(a) *[CIC §790.03(h)(1)]	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	3
CCR §2695.11(b) *[CIC §790.03(h)(3)]	The Company failed to provide to the claimant and assignee, if any, an explanation of benefits including, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.	3
CCR §2695.5(e)(3) *[CIC §790.03(h)(3)]	The Company failed to begin investigation of the claim within 15 calendar days.	2
CCR §2695.5(b) *[CIC §790.03(h)(2)]	The Company failed to respond to communications within 15 calendar days.	1
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	1
Total Number of Citations		29

*DESCRIPTORS OF APPLICABLE UNFAIR CLAIMS SETTLEMENT PRACTICES

- CIC §790.03(h)(1) The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.
- CIC §790.03(h)(2) The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
- CIC §790.03(h)(3) The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.
- CIC §790.03(h)(13) The Company failed to provide promptly a reasonable explanation of the bases relied upon in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

TABLE OF CITATIONS BY LINE OF BUSINESS

<p style="text-align: center;">ACCIDENT AND DISABILITY 2008 Written Premium: \$19,782,732</p> <p>AMOUNT OF RECOVERIES \$610.87</p>	<p style="text-align: center;">NUMBER OF CITATIONS</p>
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	10
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	9
CCR §2695.4(a) [CIC §790.03(h)(1)]	3
CCR §2695.11(b) [CIC §790.03(h)(3)]	3
CCR §2695.5(e)(3) [CIC §790.03(h)(3)]	2
CCR §2695.5(b) [CIC §790.03(h)(2)]	1
CIC §790.03(h)(5)	1
<p style="text-align: center;">TOTAL</p>	<p>29</p>

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report.

In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Company was asked if it intends to take appropriate corrective action in all jurisdictions where applicable. The Company has taken or will take similar corrective actions in other states where the findings identified by the Department might be inconsistent with such other state's insurance laws.

Money recovered within the scope of this report was \$610.87 as described in section number 3(b) below. As a result of the examination, the total amount of money returned to claimants within the scope of this report was \$610.87.

ACCIDENT AND DISABILITY

1. **In ten instances, the Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.** Specifically, the Company failed to reference the California Department of Insurance in its explanation of benefits, letters or e-mails denying or rejecting all or part of the claim. The Department alleges these acts are in violation of CCR §2695.7(b)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the errors in these instances. Since the date of the referenced claims, the Company purchased and implemented additional software to automate the letters generated by its claim department. This automation process provides the Company with additional assurances that certain state-mandated information, such as the contact information for the California Department of Insurance on claim denial letters mailed to California policyholders, is included with correspondence. Additionally, the Company has modified its claim department procedures so that the claim analysts are no longer

permitted to create letters outside of the system software without the permission of the claim department manager. All letters created outside of the system must also be reviewed and approved by management.

Although the Company agrees the claim analysts did not include reference to the California Department of Insurance in these instances, the Company does not find that the facts support a finding of an unfair practice under CIC §790.03(h)(3). The occasional failure to provide the required information on the part of the claim analyst is unrelated to the Company's obligations to investigate and process claims in a timely manner.

2. In nine instances, the Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given or the Company failed to provide in its written denial a reference to and explanation of the applications of specific statutes, applicable laws, and policy provisions, conditions or exclusions. The Department alleges these acts are in violation of CCR §2695.7(b)(1) and are unfair practices under CIC §790.03(h)(13).

2(a). In seven of the nine instances, the Company failed to send denial letters for claims filed against policies that were rescinded.

Summary of the Company's Response to 2(a): The Company has endeavored to send all claim denial letters in accordance with the applicable California insurance statutes and regulations as the Company has interpreted them.

While the Company believes its previous processes and procedures were fully in compliance with California insurance regulations, it is always the Company's desire to improve its practices and work with the California Department of Insurance in good faith to reasonably resolve any concerns and provide its policyholders with the best communication possible. As a result of the examination, the Company began including a specific denial of claims in its letter to the policyholder requesting an explanation of an apparent application misstatement and in its letter to the policyholder after the Company's final determination to rescind the policy has been made.

2(b). Two of the nine instances occurred in the same claim. Specifically, in one instance, the Company failed to send a partial denial letter for not paying the claimed disability for a specific nine-day period. In the second instance, the Company failed to reference in its denial letter the definition of total disability which the Company deemed to be the reason for the denial.

Summary of the Company's Response to 2(b): The Company acknowledges that a partial denial letter was not sent in the first instance, but stated that this particular claim was not representative of the typical claims adjudicated by the claim department. Accordingly, "the handling of this claim is not indicative of the business processes and settlement practices established by the Company." As a result of the examination, the claim department modified its procedures and enhanced training to ensure partial claim

denial letters are mailed when appropriate. Additionally, the claim department will hold monthly meetings to monitor compliance. Although the Company does not agree it violated the regulation in the second instance, it has changed its claim denial template to not only reference the policy provision, but to also quote the definition of total disability contained in the policy. The Company further disagrees that one claim with two instances rises to the level of a violation under §790.03(h)(13) or indicates a general business practice.

3. In three instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. Specifically, the Company failed to disclose the applicable daily/monthly disability benefit amount to the insured. The Department alleges these acts are in violation of CCR §2695.4(a) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: Although the Company disagrees that the accidental temporary omission of the daily/monthly benefit amount constitutes a violation under CCR §2695.4(a), the Company corrected the accidental omission from the explanation of benefits page on or near November 17, 2008. As a result of a major mainframe programming conversion, the daily/monthly disability benefit was inadvertently omitted from the explanation of benefits. As soon as the Company discovered this omission, it was corrected. The Company also disagrees that the temporary omission of the daily/monthly benefit amount would qualify as a misrepresentation of a pertinent fact relating to coverage under CIC §790.03(h)(1). The Company further objects to any indication that the instances were "knowingly" made or committed with the required frequency to constitute a general business practice.

4. In three instances involving the same claims referenced in #3 above, the Company failed to provide to the claimant and assignee, if any, an explanation of benefits including, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits. Specifically, the explanation of benefits fails to disclose a clear computation of benefits. The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: While the Company acknowledges these criticisms, the Company disagrees it violated CCR §2695.11(b). Once the accidental omission of the daily/monthly benefit provided on the explanation of benefits as referenced in #3 above was discovered, the information was added back to the explanation of benefits. The Company further disagrees that the facts support a violation of CIC §790.03(h)(3). The temporary accidental omission of the daily/monthly benefit amount does not equate to failure to adopt and implement standards for the investigation and processing of claims.

5. In two instances, the Company failed to begin investigation of the claim within 15 calendar days. The Department alleges these acts are in violation of CCR §2695.5(e)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges it failed to begin investigation of these two claims within regulatory guidelines, and that these two claims are not representative or reflective of the Company's consistent record of prompt investigation of claims and prompt claim payments. The Company implemented several changes in the claim department to ensure compliance with this standard. Most importantly, in order to keep investigations timely, it expanded the claim department staff from eight employees (as of December 31, 2007) to 19 employees as of the spring of 2011. This additional staff allows the Company to better manage its claim volume at all times, including peak periods and holidays. Additionally, physical files of open claims are now kept in chronological order by date received. This allows the claim manager to better track the claims to ensure that all are investigated within 15 days. Furthermore, the claim department continues to work with the Company's information technology department to enhance and automate the tracking of pending (open) claim files. Once completed, this will provide the claim examiners and claim manager with additional real-time information about the status of each claim, including those that are nearing various deadlines and require immediate attention, to allow for more efficient management and compliance review. Although the Company agrees it failed to begin investigation within regulatory guidelines, the Company asserts that these two instances were not knowingly committed or performed with sufficient frequency to constitute a violation under CIC §790.03(h)(3).

6. In one instance, the Company failed to respond to communications within 15 calendar days. Specifically, the Company failed to respond to the insured's correspondence within regulatory guidelines. The Department alleges this act is in violation of CCR §2695.5(b) and is an unfair practice under CIC §790.03(h)(2).

Summary of the Company's Response: The Company agrees with this criticism. Since the time of the investigation into this rescission, the Company's Claim Review Committee and Policy Review Committee now both meet twice weekly to ensure prompt handling and responding in similar situations. The members of both committees have been instructed to review all correspondence received from an insured in relation to a claim or a request for explanation in a misrepresentation investigation during the first meeting which occurs after the receipt of such correspondence. If appropriate, the committees will also respond to such communication within the time period provided. The increased frequency of meetings held to discuss potential rescissions (currently, two meetings per week) allows for better compliance with this regulation. Although the Company agrees it failed to respond within regulatory guidelines, the Company disagrees that this single instance could constitute a violation of CIC §790.03(h)(2).

7. In one instance, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company's Response: The claim was processed with the first date of total disability of March 7, 2008. This date was used to determine the initial period of total disability because it was the date that the physician attested to as the

“Date of First Symptom (if sickness).” Additionally, the March 7, 2008 date was also listed on the claim form by the physician as the “Date first consulted for this condition.” This date is relevant to the beginning period of total disability, as the policy states that “total disability must... (b) require the regular attendance of a Physician, except when the Physician states that care is no longer required because the Insured has reached the maximum point of recovery”. Since the claimant did not seek the regular attendance of a physician until March 7, 2008, it seemed reasonable to conclude that the claimant did not meet the definition of total disability until that date. However, since the date of this claim, the Company’s claim department has modified its procedures. In the rare claims where the initial date of total disability provided by the physician conflicts with the initial date of medical consultation/treatment, the claim department now obtains additional information from the physician to better determine the actual onset of the total disability or, if such information cannot be obtained, may use the date most favorable to the claimant. Accordingly, the claim department reopened this claim.

As a result of the findings of the examination, the Company issued payment of \$610.87, which includes interest. Although the Company reopened the claim and issued payment, the Company strongly disagrees that this single action, supported by policy language, rises to the level of a violation under CIC §790.03(h)(5).